Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST - FORT WORTH
3255 W PIONEER PKWY
ARLINGTON TX 76013-4620

Respondent Name

CITY OF FORT WORTH

Carrier's Austin Representative Box

Box Number 4

MFDR Tracking Number

M4-09-6381-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have also attached the print outs from the Medicare fee schedule for your review. Please submit this claim for the correct allowable, as it was not even reimbursed at 125% of the Medicare allowable, we feel this should be processed at 200% as the fee schedule changed at 7 days after the last day of service. "

Amount in Dispute: $458.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are requesting this dispute be dismissed. The DWC postmark date is February 23, 2009. The dates of service on the UB-04 summary form are from January 24, 2008 to February 21, 2008… Since the request for medical dispute resolution was made more than a year after the dates of service, the provider is not eligible to have the dispute considered.""

Response Submitted by: Argus Services Corporation, 9101 LBJ Freeway, Suite 600, Dallas, Texas 75243

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2008 to February 23, 2008	Outpatient Hospital Services	$458.95	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the

absence of an applicable fee guideline.

3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. 28 Texas Administrative Code §102.3 sets out general provisions regarding computation of time.
5. This request for medical fee dispute resolution was received by the Division on February 23, 2009.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – Duplicate claim/service.
   - W3 – Additional payment made on the appeal/reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 97L – The benefit for this service is included in the payment/allowance for another service./procedure that has already been adjudicated. *Code 97010 is bundled into the payment for all other services including but not limited to office visits & PT per the [sic]
   - 16D – Claim/service lacks information which is needed for adjudication. *Start and end time for each session and or procedure and or testing, not included in submitted information. *

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states that "A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." Per 28 Texas Administrative Code §102.3(a)(3), effective April 28, 2005, 30 *Texas Register* 2396, "unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day." The request for dispute resolution of services rendered on dates of service January 24, 2008 through February 19, 2008 was received by the Division on February 23, 2009. This date is later than one year after the dates of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution. Therefore service dates January 24, 2008 through February 19, 2008 will not be considered in this review. However, the Division notes that February 21, 2009 was a Saturday and not a working day per §102.3(a)(3). The next working day was February 23, 2009. The Division concludes that the request for dispute resolution of services rendered on February 21, 2008 was submitted in accordance with the timely filing requirements of §133.307(c); therefore, the services rendered on February 21, 2008 will be considered in this review.
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective January 17, 2008, 33 *Texas Register* 428, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "we feel this should be processed at 200% as the fee schedule changed at 7 days after the last day of service."
   - The requestor did not submit documentation to support that reimbursement should be calculated at 200% of the Medicare allowable.
   - The requestor asks for reimbursement according to the provisions of the *Hospital Facility Fee Guideline—Outpatient*, as set forth in Texas Administrative Code §134.403, effective March 1, 2008, 33 *Texas*

Register 400, which, although not effective until March 1st, 9 days after the dates of service in question, and not applicable to the services in dispute, the requestor argues the methodology for calculating reimbursement under the new rule would provide a fair and reasonable methodology for reimbursement of the disputed services which were roughly contemporaneous with similar services for which the new rule was intended.

- However, the payment adjustment factor of 200% that the requestor proposes would not be applicable to the services in dispute, even were §134.403 applicable.
- Per Medicare policy, CPT code 97010 is considered a bundled service for which the reimbursement is included in the reimbursement for the primary procedure performed on the same date of service. No reimbursement is separately payable for CPT code 97010.
- CPT code 97140 has a status indicator of A, which indicates services paid under a fee schedule or payment system other than OPPS. Per §134.403(f), "…the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula…"; however, CPT code 97140 is not reimbursed under OPPS, and the 200% payment adjustment factor would not be applicable.
- Rather, were §134.403 applicable to the services in dispute, then according to §134.403(h) "For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided." Under Medicare policies, CPT code 97140 performed in an outpatient hospital setting would be reimbursed according to the medical fee guideline for professional services. Therefore, were §134.403 applicable to the services in dispute, reimbursement would be calculated under the Division's medical fee guideline for professional services.
- The Division did have a medical fee guideline for professional services that was applicable for the date of service in dispute. While this fee guideline is not applicable to the services in this dispute, as the services in dispute are hospital facility fees and not professional medical fees, were we to apply the methodology of that rule, then per Texas Administrative Code §134.202(c)(1), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: for service categories of... Physical Medicine and Rehabilitation … the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." The Medicare reimbursement amount for CPT code 97140 for this facility on date of service February 21, 2008 was $24.87. This amount multiplied by 125% is $31.09. This amount multiplied by 2 service units is $62.18. This amount less the amount previously paid by the insurance carrier of $62.18 would leave an amount due to the requestor of $0.00.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	February 24, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.